R.I. DEPARTMENT OF HUMAN SERVICES
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

GENERAL INFORMATION

early intervention

Child's Name_____**ID#:**_____

Gender: Boy____ Girl_____ Date of birth_____/_____/_____

Parents____ **Legal Guardians**_____ **Surrogate Parents**_____

1) Name_____

Address_____

_____

Home phone_____ Work _____

Cell Phone _____ Email_____

2) Name_____

Address_____

_____

Home phone_____ Work _____

Cell Phone _____ Email_____

3) Emergency Contact _____

Phone _____

Who are the people involved with the child on a regular basis?

Name_____Relationship_____Age___

_____

_____

_____

_____

_____

Primary language used at home_____

Is an interpreter needed? Yes_____ No_____

Early Intervention Program _____

Service Coordinator_____

Phone_____

RIPIN Parent Consultant_____

Phone_____

Initial Referral Date____/____/____

Made by_____

Type of IFSP and Date: **Progress Reviews and Date:**

Interim: ____/____/___ Progress Review: ____/____/___

Initial: ____/____/___ Progress Review: ____/____/___

Annual: ____/____/___ Progress Review: ____/____/___

If the initial IFSP is over 45 days from referral or the annual IFSP is over 12 months, please indicate why (use back of this page for further clarification, if necessary):

___child illness/hospitalization ___family requested delay
___unable to contact/family cancellation ___provider issue

Professionals/Programs Currently involved with the Family

Name_____Phone_____

Name_____Phone_____

Name_____Phone_____

Name_____Phone_____

Planning for Transition at age 3

Anticipated Transition Referral Date_____

Contact Person:_____

Child's Name:_____

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ABOUT MY CHILD

Early Intervention focuses on supporting your child's development in his/her everyday activities with your family. Please tell us more about your child:

1. How I describe my child:_____
   _____
   _____
   _____

2. Things my child does well:_____
   _____
   _____
   _____

3. The people, places, & activities my child enjoys:_____
   _____
   _____
   _____
   _____

4. Any activities or part of child's/family's routine which are difficult for my child (e.g., feeding, bedtime, playing with other children, etc.):
   _____
   _____
   _____
   _____

5. Questions I have about my child's development:
   _____
   _____
   _____
   _____
   _____

ABOUT OUR FAMILY

The following questions (#6-9) will help us learn more about your family, the activities you enjoy together, and how EI could be helpful. Your IFSP will be based on the areas that are most important to you in relation to your child's development.

If you choose not to answer these questions #(6-9), your family will still receive appropriate services, if your child is eligible.

I consent to providing the following information about our family's strengths, concerns, and priorities.

_____ _____
Signature ***Date***

6. The people, places, & activities our family enjoys:_____
   _____
   _____
   _____

7. Great things about our family (our strengths):_____
   _____
   _____
   _____

8. People, activities, and/or organizations, that help our family,(e.g., moms & tots group, grandparents, faith communities, YMCA, etc):
   _____
   _____
   _____
   _____

9. What else would be helpful for our child/family? (Information, resources)_____
   _____
   _____
   _____

Child's Name:_____

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HEALTH INFORMATION

Child's Medical Home: Is there a particular doctor's office, health center, or other place you regularly take your child for check-ups, shots, or illness?
Yes____ **No**____

If yes, list the name, mailing address, and phone number of this health provider or center.

Name_____

Mailing Address_____
_____
_____

Phone_____

Child's General Health:

When was the last time your child had a well-child (general) check- up?
Date: ___/____/____

Does your child have a medical diagnosis? **Yes**____ **No**____
If so, what is it?
_____
_____
_____
_____

Does your child see any medical specialists? **Yes**____ **No**____
If so, please list them.
_____
_____
_____
_____

Is your child taking any medication regularly (including over the counter)? If so:

Reason	**Type**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vision: Has your child's vision been tested? **Yes**____ **No**____
If so, when: ____/____/____ Where:_____

Are there any concerns about your child's vision? **Yes**___ **No**___
If so, please specify _____
_____
_____

Lead: Has your child been tested for lead? **Yes**____ **No**____
If so, when: ____/____/____ Where:_____
Was the lead level elevated? Specify:_____

If elevated, describe any steps taken or treatment provided:
_____
_____

Have you been given information about risk factors for lead exposure?_____
_____

Hearing: Has your child's hearing been tested? **Yes**___ **No**___
If so, when: ____/____/___ Where:_____

Are there any concerns about your child's hearing? **Yes**___ **No**___

If so, please specify:_____
_____
_____

Child's Name:_____

HEALTH INFORMATION

Sleep: Tell us about your child's sleep:

Trouble falling asleep at night: Yes____ No____ How many times child wakes up during the night:_____

Number hours child sleeps at night:_____ Number of hours child naps:_____

Other concerns – please specify (nightmares, snoring, etc.):_____

_____

Eating and Nutrition: Tell us about your child's eating, nutrition, and growth:

_____

_____

_____

_____

_____

_____

Additional health information and history (include pregnancy and birth history, hospitalizations, relevant family medical history, mental health, behavioral issues, etc.): _____

_____

_____

_____

_____

_____

Child's Name:_____

Present Levels of Development

Parent's Questions for Assessment:

What My Child's Assessment Looked Like:

(Family and team to describe where it took place, child's behavior and interaction, family role, adaptations)

A SUMMARY OF WHAT THE TEAM, INCLUDING THE FAMILY, HAS LEARNED ABOUT THE CHILD'S DEVELOPMENT:

Body and Muscle Development, Moving, Using Hands (Gross and Fine Motor Skills)

Things my child does well, and things my child finds difficult or needs help with:

*__Things my child does well:__ Describe the child's current and emerging skills and strengths, <u>as they relate</u> to participating in daily routines, activities, and learning opportunities.

****Things my child finds difficult or needs help with:** Describe what the child finds difficult or avoids, or what prevents the child from actively participating in daily routines, activities, and learning opportunities.

Child's Name:_____

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Present Levels of Development

Understanding and Communicating (Receptive and Expressive Communication)

Things my child does well, and things my child finds difficult or needs help with:

Playing, Thinking and Exploring (Cognitive Skills)

Things my child does well, and things my child finds difficult or needs help with:

*__Things my child does well:__ Describe the child's current and emerging skills and strengths, as they relate to participating in daily routines, activities, and learning opportunities.

****Things my child finds difficult or needs help with:** Describe what the child finds difficult or avoids, or what prevents the child from actively participating in daily routines, activities, and learning opportunities.

Child's Name:_____

Present Levels of Development

Interacting with Others (Social/Emotional Skills)

Things my child does well, and things my child finds difficult or needs help with:

Eating, Dressing, Toileting, Sleeping (Adaptive Skills)

Things my child does well, and things my child finds difficult or needs help with:

*__Things my child does well:__ Describe the child's current and emerging skills and strengths, as they relate to participating in daily routines, activities, and learning opportunities.

****Things my child finds difficult or needs help with:** Describe what the child finds difficult or avoids, or what prevents the child from actively participating in daily routines, activities, and learning opportunities.

Child's Name:_____

Summary of Assessment Results

Date of Assessment: ___/____/___ Summary:

____Child **eligible** due to: ____ Multiple Established Conditions _____Single Established Condition _____Developmental Delay _____Clinical Judgment

_____/_____ _____/_____
Diagnosis Code Diagnosis Code

____Child is **not eligible** due to reason stated above. Referral to:_____

NAMES OF MULTIDISCIPLINARY TEAM MEMBERS AND OTHERS WHO PROVIDED INFORMATION ABOUT THE CHILD'S DEVELOPMENT

Name	Discipline or Family Role	Name	Discipline or Family Role

Methods and Procedures Used	Assessments Used
___ Review of medical records ___ Developmental history ___ Family report ___ Routines-based interview ___ Observation of child ___ Language samples ___ Play-based evaluations	Developmental checklist (specify): _____ Criterion-referenced/curriculum based instrument (specify): _____ Norm-referenced instrument (specify): _____ Other (specify): _____

Results Summary

Results include standard score, T-score, developmental age, performance level, or whether or not concerns were identified. (Please note that in general, Standard Scores (SS) between 85 and 115 are considered to be within normal limits, as are T-Scores between 40 and 60.)

Developmental Domain	Result	Data Code	Developmental Domain	Result	Data Code
COGNITIVE:			ADAPTIVE SKILLS:		
GROSS MOTOR:			VISION:		
FINE MOTOR:			HEARING:		
EXPRESSIVE COMMUNICATION:			GROWTH:		
RECEPTIVE COMMUNICATION:			IMMUNIZATIONS:		
SOCIAL/EMOTIONAL:			FAMILY RESOURCES/PRIORITIES:		

Child's Name:_____

Concerns and Priorities

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List the Family's Concerns and Identify Immediate Priorities

- Thinking about all of the information that we've gathered up until now, what are your current concerns related to your child's development?

- List any other concerns identified by other team members during the assessment process.

- Looking at this list, what would you like to focus on in the next few months?

Child's Name: _____ Date: _____

OUTCOME

What we want to happen is:

_____

_____

What is happening now:

_____

_____

What will happen (short-term, measurable objectives or a measurable statement of outcome):	
Strategies (methods for working on this outcome during your child and family's daily activities and routines):	What support do you need to use these strategies?
Review Date(s): Has this outcome been achieved? Please summarize:	

IFSP Start Date: _____ Child's ID: _____ Child's Name: _____ IFSP TYPE : ____Interim ____Progress Review

IFSP End Date: _____ ____Initial ____Progress Review

Review Date(s): _____ Review Date(s): _____ ____Annual ____Progress Review

EARLY INTERVENTION SERVICES - SUMMARY

Early Intervention Services (EIS)	Provider (Role/Org.)	Location	Method of Service (C/G/I*)	Nat. Env.? Y/N (if no, complete page 12)	Freq. (# times per month)	Intensity (length of session)	Date of Initiation	Duration (months)	Payment Source	Status

Status Codes:
1 – in progress
2 - anticipated
3 - interrupted
4 - completed
5 - family declined service
6 - family postponed

*Consult, Group, or Individual

Child's Name: _____

JUSTIFICATION FOR EARLY INTERVENTION SERVICES THAT CANNOT BE ACHIEVED SATISFACTORILY IN A NATURAL ENVIRONMENT

"… one of the most important outcomes that we can support is for young children with special needs to fully participate in their everyday world, rather than be excluded from life experiences that other children have. …natural environments encompasses the knowledge that children learn best in the context of everyday routines, activities, and places. … This decision to provide services in other locations must be made by the IFSP team. The justification for this decision must be based on child and family need and documented in the IFSP." (Operational Standards, May 2000).

List any service that will not be provided in a natural environment, the page(s) of the outcome(s) that the service is addressing, and where the service will be provided:

Explain why the child's outcome(s) could not be achieved in a natural environment with supplementary supports. If the child has not made satisfactory progress toward an outcome in a natural environment, include a description of why the outcome was not modified or alternative natural environments have not been selected:

Explain how services provided in this location will be generalized to support the child to function in his/her natural environment. Include what supports will be provided to parents and other caregivers to help them use strategies that are successful in their everyday settings.

Date completed: Date to be reviewed:

ACKNOWLEDGMENT OF IFSP

Child's Name:_____

I HAVE PARTICIPATED IN THE DEVELOPMENT OF THIS IFSP, I HAVE READ THIS IFSP, AND THE CONTENTS OF THE IFSP HAVE BEEN FULLY EXPLAINED TO ME.

_____ I have been informed of my right to due process and procedures (procedural safeguards).

_____ I do approve of this plan for my child and family.

_____ I do not approve of _____, _____,

_____ services for my child and family, and I would like the following changes made:

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**

Other IFSP Team Members:

Service Coordinator:_____ Date:_____

Other Team Member:_____ Date:_____

Other Team Member:_____ Date:_____

Other Team Member_____ Date:_____

IFSP REVIEW

CHILD'S NAME _____ CHILD'S DOB_____

The IFSP is a working document that must be reviewed every six months and revised annually. It can be reviewed more frequently, and changes can be made at any time that the family and program agree it is necessary. If services are added or dropped, or if frequency changes, the service page must be updated. As part of an IFSP review, outcomes must be reviewed and progress summarized on those pages.

Review Date _____

Summary of Discussion:

Describe the child's overall progress. How are EI services supporting the child and family's participation in desired activities? What changes would be helpful?

_____ _____

Parent/Guardian Signature **Date**

Other IFSP Team Members:

Service Coordinator:_____ Date:_____

Other Team Member:_____ Date:_____

Other Team Member:_____ Date:_____

Other Team Member_____ Date:_____

INDIVIDUAL TRANSITION PLAN

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If it has been more than 6 months between IFSP and review date, please indicate reason:

CHILD: **DOB:**	**EI AGENCY**	**SCHOOL DISTRICT:**
ADDRESS:	**CONTACT:**	**CONTACT:**
PHONE:	**PHONE:**	**PHONE:**
PARENT/GUARDIAN:		

Transition Timeline Dates		**INFORMATION PROVIDED TO FAMILY (please check information on CEDARR Referral:**	
Referral to LEA	IFSP given to LEA	Copy of LEA Procedural Safeguards	
Transition Planning Meeting	Evaluation Team review of referral	How to receive RI Special Education Regulations	
Eligibility Determined	IEP Meeting	Special Ed. Parent Advisory Board Contact Info	

FAMILY STATEMENT/GOALS FOR TRANSITION:

CURRENT STATUS (e.g. developmental progress/continuing areas of need, services, outside providers, educational surrogate parent):

Transition Meeting Attendance

PARENT/GUARDIAN:	SERVICE COORDINATOR
SCHOOL REPRESENTATIVE:	OTHERS:

Child's Name: _____

WHAT ARE THE NEXT STEPS NEEDED TO DETERMINE ELIGIBILITY? , ? (e.g., record exchange with release, additional evals, observation of child)			
Who	**What**	**When**	**Date Completed**
WHAT ADDITIONAL TRANSITION INFORMATION WOULD THE FAMILY LIKE? (e.g., parent-to-parent, workshops, observe various early childhood learning and/or service settings)			
Who	**What**	**When**	**Date Completed**
WHAT ADDITIONAL INFORMATION WILL HELP TO PLAN FOR THE FURTURE? School and/or community "*PEOPLE, PLACES, AND ACTIVITIES"* (e.g., observations of child in group plan, progress updated, information needed if considering ESY, community options, additional assessments, self-help skills, communication/health/technology needs)			
Who	What	When	Date Completed
_____Is not eligible for special education and/or related services. Information and/or referrals for the following community resources were provided to the family:			

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ADDITIONAL PLANNING STEPS

This page is to be used to document planning and next steps as the transition period moves forward and more information is gathered and/or needed.

Who	What	When	Date Completed